

(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section with respect to pediatric oral care benefits;

(5) The plan described in paragraph (b)(3)(i) of this section with respect to pediatric vision care benefits; and

(6) A habilitative benefit determined by the plan as described in §156.115(a)(5) of this subpart or by the State as described in paragraph (f) of this section.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in §156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in §156.110(f) of this subpart, include habilitative services in a manner that meets one of the following—

(i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Is determined by the issuer and reported to HHS.

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not

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offer the services described in § 156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

§ 156.122 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the Exchange, the State, or OPM.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in § 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.

§ 156.125 Prohibition on discrimination.

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

(b) An issuer providing EHB must comply with the requirements of § 156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

§ 156.130 Cost-sharing requirements.

(a) *Annual limitation on cost sharing.*

(1) For a plan year beginning in the

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calendar year 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that is in effect for 2014; or

(ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

(2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.

(ii) For other than self-only coverage—twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.

(b) *Annual limitation on deductibles for plans in the small group market.* (1) For a plan year beginning in calendar year 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage—\$2,000; or

(ii) For coverage other than self-only—\$4,000.

(2) For a plan year beginning in a calendar year after 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage—the annual limitation on deductibles for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage as defined in paragraph (e) of this section; and

(ii) For other than self-only coverage—twice the annual deductible limit for self-only coverage described in paragraph (b)(2)(i) of this section.

(3) A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit.